



**ENT OF GEORGIA, LLC
PRIVACY POLICY ACKNOWLEDGEMENT STATEMENT**

I hereby acknowledge that I have been made aware that ENT of Georgia, LLC has a Privacy Policy in place in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

As a patient of ENT of Georgia, I understand and acknowledge the following:

1. ENT of Georgia has a privacy policy in effect in their offices.
2. ENT of Georgia has made this policy available to me for review, by placing a complete version in a binder that resides in the waiting room and/or by placing a poster version of this policy in the waiting room or similar common area with patient access.
3. ENT of Georgia has made me aware, that as a patient I am entitled to a copy of this Privacy Policy if I desire a copy for my personal file.

Upon your review of the above statements, please sign at the bottom acknowledging that you have been advised of the privacy policy implemented by ENT of Georgia, LLC and have read and understand the acknowledgment form. If you desire a copy of the Privacy Policy, please request one at this time.

_____ **No, I do not want a copy** but I acknowledge the Privacy Policy exists

_____ Yes, I **DO want a copy** of the Privacy Policy,

Patient Name:

Date:

*For more information contact the ENT of Georgia Compliance & Privacy Officer at
(770) 220-8400 or the Office of Civil Rights at (404) 347-3125*